

## § 412.86

## 42 CFR Ch. IV (10–1–11 Edition)

midpoint of the cost reporting period to the date of reconciliation.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 51 FR 31496, Sept. 3, 1986; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 15174, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39823, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997; 68 FR 34515, June 9, 2003; 71 FR 48138, Aug. 18, 2006]

### § 412.86 Payment for extraordinarily high-cost day outliers.

For discharges occurring before October 1, 1997, if a discharge that qualifies for an additional payment under the provisions of § 412.82 has charges adjusted to costs that exceed the cost outlier threshold criteria for an extraordinarily high-cost case as set forth in § 412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under § 412.82 (c) or (d); or

(b) The payment that would be made under § 412.84 (i) or (j) if the case had not met the day outlier criteria threshold set forth in § 412.80(a)(1)(i).

[53 FR 38529, Sept. 30, 1988, as amended at 62 FR 46028, Aug. 29, 1997]

#### ADDITIONAL SPECIAL PAYMENT FOR CERTAIN NEW TECHNOLOGY

### § 412.87 Additional payment for new medical services and technologies: General provisions.

(a) *Basis.* Sections 412.87 and 412.88 implement sections 1886(d)(5)(K) and 1886(d)(5)(L) of the Act, which authorize the Secretary to establish a mechanism to recognize the costs of new medical services and technologies under the hospital inpatient prospective payment system.

(b) *Eligibility criteria.* For discharges occurring on or after October 1, 2001, CMS provides for additional payments (as specified in § 412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical services and technologies, if the following conditions are met:

(1) A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diag-

nosis or treatment of Medicare beneficiaries.

(2) A medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered “new” under the criterion of this section.

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

(c) *Announcement of determinations and deadline for consideration of new medical service or technology applications.* CMS will consider whether a new medical service or technology meets the eligibility criteria specified in paragraph (b) of this section and announce the results in the FEDERAL REGISTER as part of its annual updates and changes to the IPPS. CMS will

only consider, for add-on payments for a particular fiscal year, an application for which the new medical service or technology has received FDA approval or clearance by July 1 prior to the particular fiscal year.

[66 FR 46924, Sept. 7, 2001, as amended at 68 FR 45469, Aug. 1, 2003; 69 FR 49243, Aug. 11, 2004; 73 FR 48755, Aug. 19, 2008; 74 FR 43997, Aug. 27, 2009]

**§ 412.88 Additional payment for new medical service or technology.**

(a) For discharges involving new medical services or technologies that meet the criteria specified in § 412.87, Medicare payment will be:

(1) One of the following:

(i) The full DRG payment (including adjustments for indirect medical education and disproportionate share but excluding outlier payments);

(ii) The payment determined under § 412.4(f) for transfer cases;

(iii) The payment determined under § 412.92(d) for sole community hospitals; or

(iv) The payment determined under § 412.108(c) for Medicare-dependent hospitals; plus

(2) If the costs of the discharge (determined by applying the operating cost to charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(i) 50 percent of the costs of the new medical service or technology; or

(ii) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

(b) Unless a discharge case qualifies for outlier payment under § 412.84, Medicare will not pay any additional amount beyond the DRG payment plus 50 percent of the estimated costs of the new medical service or technology.

[66 FR 46924, Sept. 7, 2001, as amended at 67 FR 50111, Aug. 1, 2002; 69 FR 49244, Aug. 11, 2004; 72 FR 47411, Aug. 22, 2007]

**PAYMENT ADJUSTMENT FOR CERTAIN REPLACED DEVICES**

**§ 412.89 Payment adjustment for certain replaced devices.**

(a) *General rule.* For discharges occurring on or after October 1, 2007, the amount of payment for a discharge de-

scribed in paragraph (b) of this section is reduced when—

(1) A device is replaced without cost to the hospital;

(2) The provider received full credit for the cost of a device; or

(3) The provider receives a credit equal to 50 percent or more of the cost of the device.

(b) *Discharges subject to payment adjustment.* (1) Payment is reduced in accordance with paragraph (a) of this section only if the implantation of the device determines the DRG assignment.

(2) CMS lists the DRGs that qualify under paragraph (b)(1) of this section in the annual final rule for the hospital inpatient prospective payment system.

(c) *Amount of reduction.* (1) For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment.

[72 FR 47411, Aug. 22, 2007]

**Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs**

**§ 412.90 General rules.**

(a) *Sole community hospitals.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) [Reserved]

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* CMS pays for kidney acquisition costs incurred by renal